MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

Early Childhood Services Bureau ♦ P.O. Box 202925 ♦ Helena, MT 59620-2925 ♦ fax: 406-444-2547

Steve Bullock, Governor

Richard H. Opper, Director

DPHHS-HCS/CC-127 (Rev 02/13)

LEGALLY CERTIFIED PROVIDER (LCP) PROGRAM
STATEMENT OF HEALTH FORM

Legally Certified Provider Name:	Provider Number (PV#):
Name:	Phone Number:
Address:	City, State, Zip Code:
Social Security Number:	Date of Birth:

Please check one of the boxes below:

☐ I am applying to be a legally certified provider. Care will be provided in my home.

☐ I am applying to be a legally certified provider. Care will be provided in the child's home.

☐ I am the spouse of the applicant.

☐ I am a member of the applicant's household.

Applicants and household members must meet certain health requirements. As the agency responsible for approving LCP/LCI payment numbers, the Department of Public Health and Human Services (DPHHS) must ensure that the health of each provider is adequate to meet the demands of the care being provided.
The CCR&R Worker overseeing the LCP/LCI materials packet and the LCP/LCI Supervisor who approves the payment number will review this form. In some cases, the answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your responses. The answer "yes" does not mean you will automatically be denied as an LCP/LCI. Your explanation, or, if necessary, your physician's or other appropriate professional's statement will be taken into consideration. The purpose of the questions is to help decide if you have any health problems that may affect your ability to safely provide care. Health information, which the CCR&R Worker assesses as needing follow up will be forwarded to the LCP/LCI Supervisor. If an evaluation or statement is needed, the Supervisor will send the required information to the LCP/LCI applicant. Any evaluations, tests, or visits to your physician or other professional(s) must be paid by the LCP/LCI applicant.

Please answer the following questions by checking the appropriate box for each question.

During the past 3 years, have you had any disabling chronic conditions, or physical, mental, or emotional illness requiring care from a physician, psychologist, or other professional?

☐ Yes ☐ No

- If "Yes," please describe. Include a description of any vision or hearing problem and any limitation on mobility. Include treatment and current status (you may use additional paper if needed).

Do you suffer from any physical or mental health limitations, which might affect your ability to provide child care?

☐ Yes ☐ No

- If "Yes," please explain (you may use additional paper if needed).

Are you currently diagnosed, receiving therapy or medication for a mental health problem, which might affect your Ability to provide care?

☐ Yes ☐ No

- If "Yes," please explain (you may use additional paper if needed).

Have you received counseling or treatment related to chemical dependency, drugs or alcohol within the past three years?

☐ Yes ☐ No

- If "Yes," please explain (you may use additional paper if needed).

Have you ever been addicted to drugs and/or alcohol or have you been treated for drug and/or alcohol abuse, within the past three years?

☐ Yes ☐ No

- If "Yes," please explain (you may use additional paper if needed).

Additional Comments:

Please read, then sign and date:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my application or for revoking my payment number should one have been issued to me on the basis of the statements I have made herein. I understand this information is confidential and is to be used only by the Department of Public Health and Human Services for the administration of the Legally Certified Provider of Child Care program. I hereby consent to the use of this information for such purposes.

SIGNATURE:_____DATE:_____

Please Return To:

Family CONNECTIONS MONTANA
202 2nd Ave. S. Ste 201
Great Falls, MT 59405

Worker's Initials:_____ DATE: _____